Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. Whether there should be additional reimbursement for date of service 11/16/01.

II. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 11/16/01.

2. The provider billed $129.00 for date of service 11/16/01.

3. The carrier reimbursed the provider $43.00.

4. The amount left in dispute is $86.00.

5. The denial code listed on the EOB is “D-DUPLICATE CHARGE.” No other denial was noted, therefore, the dispute will be reviewed as a Fee dispute.

III. RATIONALE

Medical Review Division's rationale:

The carrier supplied a copy of two EOBs that indicate they paid for CPT Code 97750-FC for date of service, 11/16/01.

General Instructions (II) indicates, “Ground rules, presented at the beginning of each section, provide definitions necessary to correctly interpret, report, and reimburse the services and procedures, contained in that section. Ground rules also provide explanations of terms that apply only to that particular section.” The Commission cannot alter the CPT codes but can develop ground rules that are more expansive in order to explain how the code is to be interpreted by the parties. It is clear from the General Instructions that the Ground Rules are not restricted by the code, but were written in order to adapt the codes for the Commission’s needs.

Therefore, the MGR should be interpreted as an expansion of the code descriptor. MGR (I) (C) (1), indicates 97750 is to be used with modifier, -FC or –MT. The appropriate section of the MGR, (I) (E), would then apply. (I) (E) (2) indicates, “FCEs are allowed a maximum of three times for each injured worker.” It also indicates the payments to be made for the 3 tests and what

elements a FCE should contain. This section also includes a description of all the elements required for a function capacity evaluation.

MGR (I) (E) (3) describes muscle testing (97750-MT). The ground rule indicates that 97750-MT , " …shall be reimbursed per body area (see section (I) (D) (1) of the ground rules for this section). Per the medical reports supplied by the carrier, the claimant had injured her right lower extremity. If two or more contiguous areas are injured and if testing requires no additional tasks, then reimbursement shall be allowed for only one body area. Muscle testing shall not be reimbursed in addition to a functional capacity evaluation (FCE). Muscle testing may be used to replace any six components of the functional abilities test and shall be reimbursed (by time required) as a component of the FCE, not exceeding the MAR for an FCE." MGR (I) (D) describes the body areas. Based on the medical report submitted, the testing did meet the component of a muscle test. Therefore, the provider incorrectly coded the muscle test by failing to use the correct modifier. The MAR for muscle testing to one body area is $43.00. The carrier had already reimbursed the provider for one body area. Therefore, additional reimbursement for the muscle test completed **is not** recommended.

IV. DECISION & ORDER

Based upon the review of the disputed healthcare services within this request, the Medical Review has determined that the requestor **is not** entitled to additional reimbursement for CPT code 97750 as identified in the above rationale.

The above Findings, Decision and Order are hereby issued this 6th day of May 2003.

Michael Bucklin
Medical Dispute Resolution Officer
Medical Review Division

MB/mb